Washington State Health Care Authority
Public Employees Benefits Board

Retiree/COBRA/LWOP Notice of Appeal

- Type or print clearly in black ink.
- Keep a copy of your completed form for your records.

If you are…	And your appeal concerns…	Follow these instructions:
• An applicant for PEBB benefits • A retiree • A survivor of a deceased employee or retiree as described in Washington Administrative Code (WAC) 182-12-265 • A survivor of emergency service personnel killed in the line of duty as described in WAC 182-12-250 • A member through COBRA, Leave Without Pay (LWOP), or PEBB Extension of Coverage • The dependent of one of the above	A decision from the PEBB Program about eligibility for benefits, enrollment, premium payments, a premium surcharge, or eligibility to participate in the PEBB (SmartHealth) wellness program or receive a wellness incentive.	Complete all sections of this form and submit it to the PEBB appeals manager as instructed on the next page. The PEBB appeals manager must receive the form **no later than 60 calendar days** after the date of the denial notice or decision you are appealing.
Seeking a review of a decision by a **PEBB health plan**, **insurance carrier**, or **benefit administrator**.	• A benefit or claim. • Completion of the SmartHealth wellness incentive program requirements or a reasonable alternative request.	Contact the health plan, insurance carrier, or benefit administrator, to request information on how to appeal its decision. **Do not use this form.**

Section 1: Appellant Information

(Select one): ☐ Retiree ☐ Applicant (not currently enrolled in a PEBB benefit) ☐ Surviving dependent ☐ Dependent of a PEBB subscriber ☐ COBRA, Leave Without Pay, or PEBB Extension of Coverage member

Social Security number	Last name	First name	Middle initial

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code

Email address (optional)	Work phone number	Home phone number

Other Enrollee Information (if appeal concerns other enrolled individuals)

Social Security number	Last name	First name	Middle initial
Social Security number	Last name	First name	Middle initial

continued

Request for Review/Notice of Appeal

Appellant's Social Security number	Appellant's last name	First name	Middle initial

Section 2: Describe Your Appeal (Be as detailed as possible. Attach additional pages as needed.)

What was the date of the denial notice or decision?

What denial or decision do you want reviewed?

Why do you disagree with the denial or decision? Please give a detailed description of your situation and attach supporting documentation. Provide a statement identifying the specific portion of the denial or decision being appealed, and clarify what you believe to be incorrect.

What would you like done about the denial or decision?

Is there any additional documentation you would like to include? (Attach additional pages as needed.)

☐ I have attached additional documents (for example, forms or correspondence between me and my employer or the PEBB Program) because I believe these documents show:

Section 3: Representative Information (Complete this section only if you have someone representing you.)

Last name	First name	Middle initial	Phone number	Relationship to appellant	Washington State Bar Association number (if applicable)

Mailing address	Apt./unit number	City	State	ZIP Code

Section 4: Signature

Sign and date this section, and keep a copy of this form for your records. **Note:** The PEBB appeals manager must receive the appeal **no later than 60 calendar days** after the date of the denial notice or decision you are appealing.

By signing this form, I declare that the information I have provided is true, complete, and correct.

Signature _____ Date _____

How to submit this form:

The PEBB appeals manager must receive the form **no later than 60 calendar days** after the date of the denial notice you are appealing. Submit this completed form by (choose one):

Mail:
PEBB Appeals
Health Care Authority
P.O. Box 42699
Olympia, WA 98504-2699

OR

FAX: 360-725-0771

OR

Email: pebappeals@hca.wa.gov